



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR SURGICAL HOSPITAL OF FORT WORTH
750 12TH AVE
FORT WORTH TX 76104-2517

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-09-7365-01

MFDR Date Received

March 31, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Respondent has failed to demonstrate accurate payment... requestor remains in the position that payment was not made according to Texas Department of Workers Compensation guidelines, we uphold our request for additional reimbursement in the amount of \$2033.59 in addition to penalty interest for the claims processing error..."

Amount in Dispute: \$2,033.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This date of service was paid based upon the Medicare reimbursement plus the percentage increase specific to this case. Reductions were also made pursuant to the multiple surgery rules. Therefore, the Provider has been correctly paid and is owed no additional reimbursement."

Response Submitted by: Downs Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, Texas 75201

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 17, 2008	Outpatient Hospital Services	\$2,033.59	\$815.57

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits with audit date of 11/24/2008

- 112-003 – THE PRIMARY PROVIDER IS A NON-CONTRACTED PROVIDER.
- 147 – Provider contracted/negotiated rate expired or not on file.
- 243 – THIS PROCEDURE HAS BEEN INCLUDED IN ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.
- 595-001 – THE REIMBURSEMENT AMOUNT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE PERCENTAGE INCREASE SPECIFIED BY THE STATE.
- 59 – Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)
- 607 – REIMBURSEMENT FOR THIS PROCEDURE HAS BEEN CALCULATED ACCORDING TO THE MULTIPLE PROCEDURE RULE.
- 857 – PROCEDURE INCLUDED IN ANOTHER CODE BILLED ON SAME DATE OF SERVICE \$0.00
- 885 – REVIEW OF THIS CODE HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF
 - \$1,135.00
 - \$1,485.00
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W1 – Workers Compensation State Fee Schedule Adjustment
 - \$0.00
 - \$1,135.00
 - \$1,485.00

Explanation of benefits with audit date of 12/24/2008

- 243 – THIS PROCEDURE HAS BEEN INCLUDED IN ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.
- 595-001 – THE REIMBURSEMENT AMOUNT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE PERCENTAGE INCREASE SPECIFIED BY THE STATE.
- 59 – Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)
- 607 – REIMBURSEMENT FOR THIS PROCEDURE HAS BEEN CALCULATED ACCORDING TO THE MULTIPLE PROCEDURE RULE.
- 857 – PROCEDURE INCLUDED IN ANOTHER CODE BILLED ON SAME DATE OF SERVICE \$0.00
- 885 – REVIEW OF THIS CODE HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF
 - \$1,135.00
 - \$1,485.00
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W1 – Workers Compensation State Fee Schedule Adjustment
 - \$0.00
 - \$1,135.00
 - \$1,485.00
- W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Explanation of benefits with audit date of 2/18/2009

- 857 – PROCEDURE INCLUDED IN ANOTHER CODE BILLED ON SAME DATE OF SERVICE \$0.00
- 885 – REVIEW OF THIS CODE HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF
 - \$1,135.00
 - \$1,485.00
 - 110.47
 - 5,711.11
- 900-001 – O-DENIAL AFTER RECONSIDERATION/BASED ON FURTHER REVIEW, NO PAYMENT IS WARRANTED.
- 983-001 – UPON FURTHER REVIEW-ADDITIONAL PAYMENT IS WARRANTED.
- W1 – Workers Compensation State Fee Schedule Adjustment
 - \$0.00
 - \$1,135.00
 - \$1,485.00
 - \$110.47
 - \$5,711.11
- W3 – Additional payment made on appeal/reconsideration.
- W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 29827 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 42, which, per OPPS Addendum A, has a payment rate of \$2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,746.76. This amount multiplied by the annual wage index for this facility of 0.9681 yields an adjusted labor-related amount of \$1,691.04. The non-labor related portion is 40% of the APC rate or \$1,164.51. The sum of the labor and non-labor related amounts is \$2,855.55. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.171. This ratio multiplied by the billed charge of \$11,070.00 yields a cost of \$1,892.97. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of \$2,855.55 divided by the sum of all APC payments is 54.52%. The sum of all packaged costs is \$1,660.57. The allocated portion of packaged costs is \$905.35. This amount added to the service cost yields a total cost of \$2,798.32. The cost of this service exceeds the annual fixed-dollar threshold of \$1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is \$0.00. The total APC payment for this service, including outliers and any multiple procedure discount, is \$2,855.55. This amount multiplied by 200% yields a MAR of \$5,711.10.
 - Procedure code 29824 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 41, which, per OPPS Addendum A, has a payment rate of \$1,833.13. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,099.88. This amount multiplied by the annual wage index for this facility of 0.9681 yields an adjusted labor-related amount of \$1,064.79. The non-labor related portion is 40% of the APC rate or \$733.25. The sum of the labor and non-labor related amounts is \$1,798.04. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$899.02. This amount multiplied by 200% yields a MAR of \$1,798.04.
 - Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 42, which, per OPPS Addendum A, has

a payment rate of \$2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,746.76. This amount multiplied by the annual wage index for this facility of 0.9681 yields an adjusted labor-related amount of \$1,691.04. The non-labor related portion is 40% of the APC rate or \$1,164.51. The sum of the labor and non-labor related amounts is \$2,855.55. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$1,427.77. This amount multiplied by 200% yields a MAR of \$2,855.55.

- Procedure code 23929 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 43, which, per OPPS Addendum A, has a payment rate of \$112.62. This amount multiplied by 60% yields an unadjusted labor-related amount of \$67.57. This amount multiplied by the annual wage index for this facility of 0.9681 yields an adjusted labor-related amount of \$65.42. The non-labor related portion is 40% of the APC rate or \$45.05. The sum of the labor and non-labor related amounts is \$110.46. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$55.23. This amount multiplied by 200% yields a MAR of \$110.46.
 - Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
4. The requestor's *Table of Disputed Services* lists the total amount paid as \$8,441.58. The respondent presented documentation to support that an additional payment of \$1,218.00 was paid to the requestor on February 19, 2009 for a total payment amount of \$9,659.58. The total recommended payment for the services in dispute is \$10,475.15. This amount less the amount previously paid by the insurance carrier of \$9,659.58 leaves an amount due to the requestor of \$815.57. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$815.57.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$815.57, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	August 14, 2012 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.